

FILED MAY 27 1943

318

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **1523**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Faith Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution **1-week**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **John E. Walsh**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**

6. (b) Name of husband or wife **Rose Walsh** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **Nov. 19th., 1873**
(Month) (Day) (Year)

8. AGE: Years **69** Months **5** Days **24** If less than one day hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Park Laborer**

11. Industry or business _____
12. Name **Patrick Walsh**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Rose Walsh**
(b) Address **2815 N. Taylor Ave.**

17. (a) **Burial** (b) Date thereof **5-17-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cemetery**

18. (a) Signature of funeral director **Arthur Bonnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **MAY 17 1943** (b) **J. J. Madala**
(Date received local health officer's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **000 12 911**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2815 N. Taylor Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **13th.**, year **1943** hour **8** minute **30** P. M.

21. I hereby certify that I attended the deceased from **1/28/43** to **5/13/43**, 19 **43** that I last saw him alive on **5/13/43**, 19 **43** and that death occurred on the date and hour stated above.

Immediate cause of death **1) Lobes pneumonia** Duration **3 days**

Due to **108**

Other conditions **2) Cardiovascular disease**
(Include pregnancy within 6 months of death)
3) Sarcoidosis

Major findings: Of operations _____ Of autopsy _____ PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **A. J. Signorelli** (M. D. or other) **MD**
Address **2801 N. Taylor** Date signed **5/17/43**

J. Signorelli
2801 Taylor Ave. Co. 8800

506261

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lucca Blvd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.